Coastal Dental Associates
118 Alden Road
Fairhaven, MA 02719
(508)994-2255

Medical & Dental History Form

Patient Name: Last | First | MI | Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 2 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications? Please list below.

☐ Do you use tobacco (smoking or chewing)?

☐ Have you ever had a blood transfusion?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If any of the previous questions are marked, please explain:

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List Of Medications:

Additional Notes:

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Please indicate if you have experienced any of the following:

- [ ] Allergy-Aspirin
- [ ] Allergy-Clindamycin
- [ ] Allergy-Codeine
- [ ] Allergy-Drug
- [ ] Allergy-Erythromycin
- [ ] Allergy-Hay Fever
- [ ] Allergy-Latex
- [ ] Allergy-Metals
- [ ] Allergy-N-Saids
- [ ] Allergy-Other
- [ ] Allergy-Penicillin
- [ ] Allergy-Sulfa
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Artificial Prosth
- [ ] Aspirin
- [ ] Asthma
- [ ] Biophosphonates
- [ ] Blood Disease
- [ ] Blood Pressure-High
- [ ] Blood Pressure-Low
- [ ] Blood Tranfusion
- [ ] Cancer
- [ ] Diabetes
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Fainting/Dizziness
- [ ] Glaucoma
- [ ] Heart Bypass
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Cholesterol
- [ ] HIV-Pos/AIDS
- [ ] Immunosupressed
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Platelets
- [ ] MEDS-Anticoag
- [ ] MEDS-BP
- [ ] MEDS-Dilantin
- [ ] MEDS-Other
- [ ] Other
- [ ] Pacemaker
- [ ] PREMED-Amox
- [ ] PREMED-Amox
- [ ] PREMED-Clinda
- [ ] PREMED-Erythromycin
- [ ] PREMED-Keflex
- [ ] PREMED-Other
- [ ] Psychiatric Care
- [ ] Radiation Tx
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] TB
- [ ] Thyroid Disorder
- [ ] Tumors
- [ ] Ulcers
- [ ] Xerostomia/Dry Mouth

Do you have any other health issues or allergies?

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Is Premed Antibiotic required prior to dental appointments?

◯ Yes ◯ No

If Yes Please Indicate Prescription Name

What is the reason for your dental visit today?

When was your last visit to the dentist, and what was performed?

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

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Authorization And Consent for Services

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I hereby authorize and give my consent for Dr Camacho/staff to administer such medications and perform such diagnostic and dental treatments as may be necessary for proper dental care. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being a root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company

I authorize Dr Camacho to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners via email, fax , telephone or internet. I authorize my insurance carrier to submit payment directly to Dr Camacho so it may be applied directly my account..

I understand that I am financially responsible for any outstanding balance for services and materials provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days.

I acknowledge I have recieved a copy of the Notice Of Privacy Practices

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient: _____

Response Date: _____